Attachment #2

MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
August 15, 2013, 9:30 am to 3:00 pm
Pleasant Hill Public Library
5151 Maple Drive, Pleasant Hill, IA
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Richard Crouch
Jill Davisson
Lynn Grobe
Chris Hoffman (by phone)
David Hudson (by phone)
Betty King
Sharon Lambert
Gary Lippe
Zvia McCormick
Brett McLain
Rebecca Peterson
Deb Schildroth
Patrick Schmitz
Marilyn Seemann
Suzanne Watson
Jack Willey

MHDS COMMISSION MEMBERS ABSENT:

Neil Broderick
Senator Joni Ernst
Senator Jack Hatch
Representative Dave Heaton
Representative Lisa Heddens
Susan Koch-Seehase

OTHER ATTENDEES:

Marilyn Althoff	Hills and Dales
Theresa Armstrong	MHDS, Bureau Chief Community Services & Planning
Bob Bacon	U of Iowa Center for Disabilities and Development
Jess Benson	Legislative Services Agency
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI
Eileen Creager	Aging Resources of Central Iowa
Diane Diamond	DHS, Targeted Case Management
Kristi Dierking	Warren County
Connie Fanselow	MHDS, Community Services & Planning
Melissa Havig	Magellan Health Services
Jane Hudson	Disability Rights Iowa
Julie Jetter	MHDS, Community Services & Planning
Bob Lincoln	County Social Services
Carrie Malone	House Republican Staff
John Pollak	Legislative Services Agency
J. Mark Roberts	Lutheran Services in Iowa
Joe Sample	Iowa Department on Aging
Renee Schulte	DHS Consultant
Rick Shults	DHS, Administrator MHDS Division
Deb Eckerman Slack	ISAC County Case Management Services
Jennifer Vermeer	DHS, Iowa Medicaid Enterprise Director
Jennifer Vitco	Wapello County

WELCOME AND CALL TO ORDER

Jack Willey called the Commission business meeting to order at 9:40 a.m., welcomed attendees, and led introductions. No conflicts of interest were identified for today's meeting. Quorum was established with 15 members present.

APPROVAL OF MINUTES

Deb Schildroth made a motion to approve the minutes of the July 18, 2013 meeting as presented. Patrick Schmitz seconded the motion. The motion passed unanimously. Chris Hoffman and David Hudson were present by phone for the vote.

COST INCREASE RECOMMENDATION

Jack Willey led a discussion by Commission members to formulate a non-Medicaid expenditures growth funding recommendation to the Department. Senate File 2315 specified that the Commission's recommendation to DHS, the Council on Human Services, and the Governor for the fiscal year that begins two years from the beginning date of the current fiscal year, which would be SFY 2016. Last year the Commission recommended 4% growth for SFY 2014 and 6% growth for SFY 2015. Jack noted that this is an unusual year of transition from the county system to a regional system, which makes it especially difficult to predict what the costs will be.

Chris Hoffman said he felt the Commission did not really have data to base an informed decision on and that they needed to identify a better process for reaching a recommendation. He said without additional information he would be inclined to abstain from any recommendation made today. Suzanne Watson commented that it is not yet clear what effect the new Iowa Health and Wellness Plan will have on current non-Medicaid expenditures. Deb Schildroth commented that residency changes were just implemented on July 1 and it is not yet clear how those changes will play out either or how many of the core services are currently available and how many need to be added. The Legislative Fiscal Viability Committee will be meeting this fall to look at the first year equalization funding and determine if it is adequate. In response to a question, Theresa Armstrong said that DHS staff has not yet determined a requested amount.

David Hudson suggested a 3% growth recommendation, saying that without information about how the Commission's recommendation will stack up against other budget demands, that would seem to be a modest, defensible, and credible growth amount. Jack Willey asked if there is any data available that the Department could provide to the Commission to help them in making their recommendation in a thoughtful way in future years. Theresa Armstrong responded that the Department would be able to provide information on the cost of services and the number of people served. Julie Jetter said that the original legislative for equalization talks about the ability for future years to add growth to the current $47.28 amount.

Suzanne Watson suggested that due to the uncertainty, rather than recommending a growth amount, the Commission could recommend that the planned "Medicaid offset" not be implemented to hold the line on funding until the real cost savings from Medicaid expansion can be determined, and re-evaluate at that time.

Motion & Vote - Suzanne Watson made a motion for the Commission to recommend maintaining status quo non-Medicaid funding without implementing the Medicaid offset until the actual cost savings to non-Medicaid services can be determined. Deb Schildroth seconded the motion. The motion passed unanimously. Chris Hoffman and David Hudson were present by phone for the vote; Betty King was not present for the vote.

A suggestion was made for Commission representatives to seek an appointment to meet with the Governor to discuss the issue.

Betty King joined the meeting.

DHS/MHDS UPDATE

Rick Shults and Theresa Armstrong reported on Department activities.

Counties & Regions - They shared an updated map of the MHDS regions and a list of the names the regions have thus far adopted. Jefferson County has appealed the Department's denial of their application for exemption from joining into a region. It will go through the regular DHS appeal process and a hearing before an administrative law judge will be held in September. If the denial is upheld on appeal, the Director would be able to assign Jefferson County to one of the forming regions.

Funding is based on county property tax dollars and the equalization funds allocated to each county. Counties will also receive some federal Social Services Block Grant Funds (formerly State Payment Program funds) based on how much of the SPP funds each county had used previously. Each county will be bringing in approximately the same amount of money they have had before and regions will need to decide how they are going to pool that money or work together to use their funds to provide services.

The 21-county County Social Services Region (shown in blue) is the largest geographically; the 9-county East Central Region (shown in deep pink) has the largest service population.

Jill Davisson said that the region including Cedar, Clinton, Jackson, Muscatine, and Scott Counties has unofficially decided on the name Eastern Iowa Mental Health-Developmental Services Region.

Administrative Rules – The Regional Core Services rules were published near the end of July and comments were due August 13th. Quite a number of comments were received and work is starting on drafting changes and responses to the comments.

Summaries of the comments and the responses will be included in the final rules document. The next step is for those comments, responses, and proposed changes to go back to the rules administrator by August 27 and from there to the Legislative Services Agency. The document will be brought back here on September 19 and the Commission will be asked to adopt them. If that happens and things progress on schedule, they will be published for the second time in the Iowa Administrative Bulletin on October 16 and will go to the Administrative Rules Review Committee (ARRC) for final review on November 12, and become effective on November 20.

In preparation for finalizing the rules, MHDS would like to bring the Commission Core Services Committee back together sometime next week to look at the comments and help decide what changes may be needed. The members of the Committee are Patrick Schmitz, Jack Willey, Susan Seehase, Suzanne Watson, Neil Broderick, and Deb Schildroth. A telephone meeting was scheduled for Thursday, August 22 at 1:00 p.m. The draft will be shared with the whole Commission prior to the meeting time and any other members who have input can share that information with one of the Committee members.

The Regional Service System rules were approved for notice by the Commission last month and will be published in the Iowa Administrative Bulletin on August 21. Comments will be due September 10 and responses are due back to the rules administrator by September 24. The Regional Rules Committee will be brought back together to review those comments as well and they should be ready for Commission action in October. The Committee will plan to meet in Des Moines on September 18, the evening before the next Commission meeting.

Autism Support Program Rules – Gary Lippe, who volunteered to represent the Commission on the Autism Expert Panel, reported on their meeting to provide guidance on the development of administrative rules for the Autism Support program. The program if for children under the age of 9 with autism spectrum disorders who don't have other coverage through Medicaid or private insurance to pay for the cost of ABA (Applied Behavior Analysis) services.

Gary said the group struggled because language in the legislation said that providers have to be Board Certified Behavior Analysts (BCBAs). Most of the people who currently provide services use non-certified people working under the supervision of a BCBA. There are only 43 BCBAs in Iowa, which means that there would be a very limited number of people to provide statewide services if only those who have the certification can be providers. The question is if the qualifications should be more restrictive to keep fidelity to the model or if there should be more flexibility to make the services more readily available and keep the cost down. The way the law that was passed reads, it does not appear to offer the flexibility for this program to use non-certified providers. Once the rules are developed they will come to the Commission for approval.

IOWA HEALTH AND WELLNESS PLAN

Jennifer Vermeer, DHS Medicaid Director presented an overview of the Iowa Health and Wellness Plan (IHAWP). She said she has been making the same presentation at public hearing across the State.

Background:

- Enacted to provide comprehensive health coverage for low-income adults who are not already eligible for Medicaid
- Begins January 1, 2014
- Covers ages 19-64 with income up to and including 133% of the Federal Poverty Level (FPL)
- Replaces IowaCare, which ends December 31, 2013

Federal approval:

- Plan must be approved by the federal government
- Some aspects are still being negotiated with CMS (Centers for Medicare and Medicaid Services)
- Some program details may change before approvals are final

The Plan has two options:

- Iowa Wellness Plan is for adults ages 19-64 with income up to and including 100% of FPL
- Marketplace Choice Plan is for adults ages 19-64 with income from 101% to 133% of FPL

Goals and objectives:

- Incentives for healthy behavior
- Focus on improved outcomes
- Emphasis on care coordination
- Local access to care

Eligibility:

- Members will be eligible for 12 months of benefits
- There will be a renewal process with income re-verified near the end of the 12 month period
- Members should notify DHS if income changes during the 12 month period

Iowa Wellness Plan:

- For persons with income up to and including 100% FPL
- 100% FPL is $11,490 for family of one; $15,510 for a family of two; dollar amount increases as the number of individuals in the household increases
- Based on modified adjusted gross income, which is an income tax based standard
- Moving away from eligibility based on gross income only

- The Iowa Wellness Plan is administered by Iowa Medicaid
- It is completely different from IowaCare, has an entirely new approach, and a much more comprehensive benefit package

Iowa Wellness Plan Coverage:

- Benefits are equivalent to the State employee benefit package (with some additions)
- Included mental health parity
- Covers habilitation similar to the way it is covered in the Medicaid program
- Covers dental services not usually covered in commercials plans
- Covers minimum essential health benefits including:
    - Physicians
    - Outpatient services
    - Emergency room and ambulance
    - Hospitalization
    - Mental health and substance use disorder services and treatment
    - Rehabilitative and habilitative services
    - Lab services, x-rays, imaging
    - Prevention and wellness services
    - Home and community based services for persons with chronic mental illness (same as covered in the Medicaid habilitation program)
    - Prescription drugs
    - Dental services

Iowa Wellness Plan Provider Network:

- Members will have access to same providers now available in regular Medicaid program
- Members will be able to choose their primary care physician
- Primary care physician will coordinate services with other providers

Iowa Wellness Plan Out of Pocket Costs:

- Different from regular Medicaid program
- It was important to policy makers that members pay something and are invested in the program
- There are no co-pays except for using the emergency room for non-emergencies
- There will be monthly premium billing for persons above 50% FLP
- The monthly contribution amount would be about 3% of the family income
- Hardship exemptions can be applied for
- There will be no monthly contributions during the first year
- Beginning in 2015, monthly contributions will be waived if members participate in certain wellness activities; more work will be done on defining what those are
- In the first year, it may be a physical and health risk assessment; in the second year it may be more of a menu that members will pick two or three things from (for example: dental check, smoking cessation program, nutritional counseling, mammogram, colonoscopy, etc.)

- Out of pocket costs cannot exceed 5% of the member's income
- About 100,000 members will be coming into the plan during the first two years, so it is important that the wellness activities are doable for the members and not a barrier to participation

Iowa Wellness Plan Program Innovations:

- Access to care coordination through establishment of health homes (medical homes) building on the current primary care structure to include dedicated care coordination
- Implementing ACOs (Accountable Care Organizations) to ensure health care providers are accountable for achieving high quality and cost effective care focused on meeting the needs of the person
- Innovations will continue to be developed through a statewide planning process related to the State Innovation Model (SIM) grant

IME has also developed a presentation on the approach to the medical home and ACO concept that has been sent out to the MAAC (Medical Assistance Advisory Committee) and can be made available to the Commission for review. These are changes that can't be done overnight, so the focus is on key components and developing a set of strategies that we can continue building on over time. The Department is working on the SIM, which is looking at implementing ACOs in Medicaid as a whole and there is a planning process going on around that.

<u>Marketplace Choice Plan:</u>

- Members will select and enroll in a commercial health plan on the Health Insurance Marketplace
- Medicaid pays the premiums to the commercial health plan on behalf of the member; this is often referred to as "premium assistance"
- Coverage will be the same as coverage for any Iowans purchasing individual coverage through the Marketplace
- Members will have a choice between at least two commercial health plans
- The Iowa Insurance Division certifies the plans that members can choose
- Iowa has chosen to use the federal-state partnership model for the Marketplace
- For people with incomes above 133% FPL and up to 400% FPL, tax credit subsidies will be available to help them afford the plan premiums

Marketplace Choice Plan Coverage:

- Coverage is equal to what is offered by the qualified health plan, which is very similar to the State employee plan
- Anything outside of that, such as dental, would be paid for by Medicaid
- Covers benefit categories including:
    - Physicians
    - Outpatient services
    - Emergency room and ambulance
    - Hospitalization

    - Mental health and substance use disorder services and treatment
    - Rehabilitative and habilitative services
    - Lab services, x-rays, imaging
    - Prevention and wellness services
    - Home and community based services for persons with chronic mental illness
    - Prescription drugs equivalent to the Medicaid benefit
    - Dental services equivalent to the Medicaid benefit
- Covered benefits that are not provided by the commercial health plan will be provided by Medicaid

Marketplace Choice Plan Provider Network:

- Uses the commercial plan's provider network of primary care, specialists, hospitals, etc.

Marketplace Choice Plan Provider Network Out of Pocket Costs:

- No copays except for non-emergency use of emergency room
- No monthly contributions during the first year (2014)
- Monthly contributions waived in future years for completing wellness activities
- Costs cannot exceed 5% of income

Marketplace Choice Plan Program Innovations:

- Purchasing private coverage
- Very similar to the way the Hawk-I program operates
- Allows people to stay enrolled in the same plan even if income fluctuates, which prevents "churning" and disruptions to treatment

<u>Medically Frail:</u>

- Federal regulations require that people who are "Medically Frail" are given the choice between the regular Medicaid State Plan or the Wellness Plan
- "Medically Frail: includes people with serious mental illness, chronic substance use disorders, serous and complex medical conditions, physical, intellectual, or developmental disabilities, and individuals who have a disability determination based on Social Security criteria
- There is still work being done on operationalizing the definition of medically frail
    - How are people identified as medically frail at the point of enrollment?
    - How can they be found by retrospective claims reviews?
    - Can we identify certain indicators or diagnosis codes?

Jennifer said that, as an example, a person who has chronic mental illness should be receiving habilitation services and anyone who is receiving habilitation services should qualify as medically frail. She said they need to be enrolled in the State Plan because that is where they can get coverage for everything they need, such as ACT teams, intensive psychiatric rehabilitation, or residential substance abuse services. It is just a

more robust set of services; folks that need more intensive services need to be in the State Plan to have access to those services, including an Integrated Health Home.

Waiver Process:

- Iowa has applied for two federal waivers – one for each plan
- Two public hearings were held at the end of July in Des Moines and Council Bluffs
- The public comment period is open until 4:30 on August 15 (today)
- On Tuesday started another round of 5 or 6 public meetings to talk about the Iowa Health and Wellness Plan and the State Innovation Model (SIM)
- Final drafts of waivers will be submitted on August 20
- The open enrollment period for both plans starts October 1; IowaCare members will have to reapply for the new coverage

Outreach and Education:

- From now through March 2014 there will be ongoing statewide outreach and education efforts
- DHS will be partnering with counties, CPCs, case managers, provider groups, and other local organizations to get information out
- The target populations are current IowaCare members and people who are uninsured, including those who are receiving county mental health services
- About 75000 of the 100,000 expected new enrollees are current IowaCare members
- There will be member benefits education once enrolled
- More information will be coming as the process continues

Application Process:

- Beginning Oct. 1, 2013 all individuals can apply through the Federal Health Insurance Marketplace at www.HealthCare.gov
- People can also apply online through DHS or at any local DHS office

More information will continue to be available online at: http://www.ime.sate.ia.us/iowa-health-and-wellness-plan.html

Questions - Jennifer Vermeer responded to questions about the changes to the Medicaid program.

Q: How long will the application process take?
A: That will be a function of the volume of applications received. Initially the aim is for less than 30 days. The process will work much as it works today. Applicants will get a notice of decision from Medicaid indicating which plan they qualify for and then they will need to choose a primary care physician or a QHP (Qualified Health Plan). There will be two questions as a first screen for identifying those who would be considered medically frail. An additional screening tool will also need to be developed. There will also need to be conversation about how Medicaid can work with counties and regions on the enrollment process.

Q: Will primary care physicians have a gatekeeper function in referring people to specialists?
A: That will also work much the same as it does now. There is a list of services where a referral would be required, just as it is now, but only certain things will require prior authorization. It is expected that will generally remain the same with the Accountable Care Organizations. In the current program, Medicaid pays $2 per member per month for the physician to serve as the primary care case manager. We need a robust provider network that is willing and able to accept these new members, so we are doubling that to $4 per member per month for the Wellness Plan members. Medicaid has also developed a voluntary physician incentive program where they can earn up to another $4 per member per month for meeting various quality standards.

Q: Are non-emergency medical transportation or retroactive eligibility included in Iowa's application?
A: No, those are points that were not covered in the state legislation, but they will be part of the negotiations with CMS.

Q: Will people in community corrections be covered?
A: That is a separate federal law, and all Medicaid rules remain the same. People who are classified as "inmates" do not qualify, which would include people on work release. Those who are in community corrections and no longer considered prisoners could be eligible under this plan when they would not have been eligible under traditional Medicaid. It is the same rules with a new coverage option.

Q: How much time will people who are now covered under IowaCares have to choose a primary care provider?
A: Probably about 10 days to make an initial choice, but they will be able to make a different choice later if they want to change.

Q: Will people on IowaCares be without coverage if they don't apply before January 1?
A: Yes, to have coverage in place on January 1, people will need to apply by about December 15.

Q: Is there an estimate on how many people will be considered medically frail?
A: The current estimate is about 10 to 15% of the population above and beyond those currently covered by Medicaid. Operationalizing the medically frail concept is challenging. The determination of who is medically frail cannot be based solely on diagnosis. For example a person could have a diagnosis of cancer and be quite well and able to function while undergoing treatment or be very ill and need a high level of care.

Q: The marketplace plan indicates that costs will be limited to 5% of income – will the only out of pocket payments will be monthly membership premiums and $10 copays for non-emergency use of ERs?
A: Yes, there are no other member copays.

Q: What about dental coverage? Will there be incentives for dentists to participate?
A: Medicaid is working on coming up with some innovative strategies for dental because they do not think that adding all these new members into the current Medicaid plan would be beneficial to the members. Barriers to dentists participating in the Medicaid program have been identified as low rates, no shows and missed appointments, and the administrative process. Those are the issues Medicaid will be trying to address. Dental services will be contracted through a commercial carrier for the 100% to 133% FPL group.

Q: Would veterans be referred to the VA health care system?
A: That could not be required. People would be referred to other options if they weren't qualified for coverage under the IHAWP, but if they are qualified it would be their choice; there could be people who are eligible for both the Iowa Wellness Plan and for VA services.

Q: Can you talk about Targeted Case Management and cost containment and explain more about how you determined the 15% increase in cost for TCM?
A: It was based on total cost, not just the state share of costs. Medicaid looked at the rate of growth in rates across the State and the total cost per member; they took a couple of different approaches, trying to adjust out for rate differences and get to the change in utilization.

Q: Cost reporting for TCM has always followed federal OMB (Office of Management and Budget) guidelines. We are now being told by IME that for cost containment there are only four things that can be included in direct costs: direct staff salaries, taxes, mileage, and normal vehicle maintenance and everything falls under the indirect cap. Why is that different from the OMB standards?
A: I don't have a lot of detail in this area, but that would be how IME has defined the indirect cost cap after looking at the numbers, and I believe that is consistent with how other providers calculate indirect costs.

Q: What is the future of case management? There are many concerns about staffing and about how people who really need assistance will be served.
A: The long-term vision for case management is in the SIM (State Innovation Model). SIM is a federal grant IME applied for from CMS on behalf of the Governor. Our national healthcare system has had tremendous cost growth, doesn't achieve great outcomes compared to other places in the world, and really isn't sustainable. CMS (Centers for Medicare and Medicaid Services) was looking for a statewide, broad-scale, multi-payer health care delivery system reform and for Governors to come in and say they want make their health care systems high quality and low cost. Governor Branstad chose to do that. The future is using integrated care delivery models. TCM provides a tremendous benefit, but there are all kinds of strings attached that limit what TCMs can do and there are a very limited set of people who receive TCM services. There is a much broader group of people who could benefit from care coordination. The future is coming up with new health care delivery models that are coordinated and integrated across all aspects of the person's life and developing models that incent and make

everyone accountable for proactive and preventative measures and outcomes. That needs to include a mechanism for care coordination and we need to adapt and evolve our system over time.

Jennifer said that we want to be careful and thoughtful about how this is done, which is why we have established workgroups to look specifically at mental health and substance abuse and long-term care. Medicaid is serving the most vulnerable populations and we want to make changes in a way that is not disruptive and does not cause harm. The SIM Workgroup information will all be available on the IME website. Rick Shults is chairing the Mental Health and Substance Abuse Workgroup. Groups will be meeting every two weeks through September.

PUBLIC COMMENT

Bob Bacon commented that the Governor of Delaware started a dialogue through the National Governors Association and shared a report called "A Better Bottom Line: Employing People with Disabilities," and encouraged other governors to take action to make the employment of people with disabilities a priority. In response, Governor Branstad and Lt. Governor Reynolds have announced they will host an employment forum in Iowa with relevant stakeholders on October 17.

A break for lunch was taken at 12:00 p.m.

The meeting resumed at 1:00 p.m.

DHS/MHDS UPDATE (continued)

Rick Shults continued the DHS/MHDS update:

RCF Closing - The Abbe Center for Community Care, a RCF (Residential Care Facility) in Linn County that had been serving about 76 adults with mental illness, is in the process of closing. The Abbe board made the decision to close the RCF and RCF-PMI by September 30, and gave a 60-day notice.

The Department is working with the Abbe organization to ensure that needed services are available the people who are moving out. DIA (Department of Inspections and Appeals) and IME have a facility in crisis team that included Magellan; they have been involved. Information has been gathered on the individuals who were living at the facility and the services they receive and other agencies have met with Abbe staff to help work out the issues. They feel they can successfully transition people to other facilities or homes in the community. The people living at the facility included a number of residents of counties other than Linn. Social workers on staff are working with CPCs and case managers to accomplish that. About 60% of the people are Medicaid eligible. About 20 people have behavioral or other challenges that may be a placement concern. This is just one residential component of the Abbe organization; the community mental health center and all other components will continue to operate.

O'Brien County – has met with some of the mental health providers and talked to them about cutting back on some current services. They experienced a situation where the change from legal settlement to residency resulted in about 40 people who were living in county-funded homes and going to work activity centers gaining residence in O'Brien County. That meant the responsibility for funding the work activity component shifted from other counties to O'Brien County, which created a large (approximately $700,000) increase in their costs. DHS has been working with them to see what options are available while they are waiting for their October property tax funds to come in. The Department remains optimistic that there are potential solutions and things can be resolved with some adjustments. One of the challenges of the transition is getting the money to where it is needed; that $700,000 is still in the system and is not being spent where it was previously being spent, but is not available to O'Brien County.

Deb Schildroth commented that she is just beginning to realize how often people move; counties probably won't be able to determine what their actual numbers are for several more months.

SIM Workgroup – Iowa now has a federal grant that is allowing us to work across the public and private sectors related to how Accountable Care Organizations can be used to address care coordination for individuals. There is a State Innovation Model workgroup that will focus on mental health and substance abuse and how that fits into the grand scheme of overall care coordination and what is expected in the ACOs. The SIM workgroup process is functioning just like the MHDS redesign workgroups.

The federal government is encouraging states to take advantage of ACOs. There are still a lot of questions about how Iowa is going to utilize that tool in a variety of different settings and circumstances, including how to effectively use an ACO and incorporate that with the work being done with mental health and substance abuse treatment. The legislature deserves a lot of credit for including a comprehensive package of mental health services in the Iowa Health and Wellness Plan. The Medicaid agency is very interested in coordinating with mental health, substance abuse, intellectual disability, and long-term care services, bringing the concepts together so that the needs of people with all those issues can be met through the ACOs.

Typically, ACOs are very medically oriented, and not comprehensive, and there is a difference between the outcome expectations that are typical to an ACO and the outcome expectations for people with mental illness and substance use issues. The goal is for people to live safe, healthy, self-determined lives in their communities, so there would need to be a focus on quality of life and access to supportive services, not just medical outcomes. Iowa can learn from good models that have been created in other states.

Community Services Consultant - Robyn Wilson's position will be posted in the near future and will be filled.

SAMHSA Site Visit – SAMHSA (Substance Abuse and Mental Health Services Administration) will be conducting a site visit to Iowa regarding the Community Mental Health Services Block Grant on September 24, 25, and 26. The SAMHSA team will meet with state staff, members of the Mental Health Planning and Advisory Council, consumers of services, and providers. They are interested in talking about what is going on with Medicaid expansion and MHDS services redesign in Iowa.

Equalization Funds – A good portion of the eligible counties have received their equalization funds because they have either paid all their state Medicaid bills or agreed to a payment plan. All of the counties that need payment plans have contacted the Department and substantial progress has been made since last month.

28E Agreements – ISAC has developed some guidelines for the agreements. The Department and ISAC have met to discuss them and there is no difference of opinion with their recommendations. The guidance should be going out within a week.

Jack Willey said he would like that information to come to the Commission as well.
Iowa Juvenile Home – The IJH superintendent retired in February and the clinical director resigned. Mark Day, who is also the superintendent of the State Training School for Boys at Eldora, was appointed as interim superintendent, and has been working with the staff to address program issues. There has been a lot of growth and improvement during the last six months and that is expected to continue. Starting last fall Disability Rights Iowa (DRI), has been making regular visits and DHS has been working with them to address areas of concern they raised. There has been a lot of press coverage about what may have been happening in the past. Youth being placed in long-term seclusion is not happening now. Staff members have received intensive training, and as of the end of June, the use of seclusion had been reduced by 81% and that downward trend continues. Rick said he is pleased with the progress that has been made and DHS will continue to work with DRI.

IJH serves youth up to age 18; the average age is probably 15 to 16. Most of the youth who go to the Toledo facility have had 8 to 10 prior out of home placements, including PMICs (Psychiatric Medical Institution for Children) and psychiatric hospitalizations, and they have all had very significant challenges in their lives. The issue is finding methods to support them when they display extremely challenging behaviors without relying on seclusion.

VA MENTAL HEALTH SERVICES AND PTSD

Brett McLain presented information on Veteran's Administration (VA) Mental Health Services and Post Traumatic Stress Disorder (PTSD) in Military Veterans.

Brett is the Story County Veteran's Affairs Director. Story County has a two-person office that is open 40 hours a week. They are currently also overseeing the Boone County office. Every county should have a VA county director available to help veterans. The state provides a $10,000 a year grant for county veteran's offices. The

staff are trained and nationally accredited as service officers. Depending on population, the offices are open from 20 to 40 hours a week.

Prior to January 3, 2003, all honorably discharged Veterans were eligible for VA healthcare; beginning on that date, veterans had to fill out an application and financial information to qualify for healthcare and mental health services. There are exceptions for veterans who were POWs (prisoners of war), have a service-connected disability, were awarded a Purple Heart, or served in-county in Vietnam. For all others who weren't in the system prior to the 2003 date, it depends on household income and assets.

There is a 30-30-20 goal: to be within 30 miles of every veteran, to get them an appointment within 30 days, and to make sure they wait no longer than 20 minutes for their appointment. Currently there are 875 claims pending for service-connected disabilities. The time to get a determination on a claim is running about 18 to 23 months, which is a long time for someone waiting for services.

The VA is concerned about how well equipped they are to handle the mental health needs of veterans. Veterans have a crisis hotline available to them at 800-273-8255. As of December 31, 2012, the hotline had received about 747,000 calls and saved more than 26,000 veterans in imminent danger. More than 1.3 million received VA mental health care in 2012. The VA is being more proactive about finding veterans with mental health needs.
Services are available at the main hospital facility in Des Moines and in Iowa City, and Community Based Outpatient Clinics (CBOCs) in Knoxville, Mason City, Fort Dodge, Marshalltown, and Carroll. Acute psychiatric care and substance abuse treatment are provided by staff with specialized expertise in the main hospital in Des Moines.

The Behavioral Recovery Unit (BRU) is a unit designed for veterans with skilled nursing care needs and disruptive behaviors, usually related to cognitive deficits or severe mental illness. The goal of the BRU is to decrease the disruptive behaviors so veterans can move to less restrictive settings in the community.

The Central Iowa Mental Health Residential Rehabilitation Program (MHRRTP) is a patient-centered, recovery-oriented treatment program. It includes programming tracks for mental health, PTSD, substance abuse, and homelessness and utilizes evidence-based therapies. All veterans have access to auxiliary groups that deal with specific areas. Veterans work individually with a case manager and a treatment team to develop an individualized plan of care and discharge plan.

PTSD is still a difficult issue for many veterans to deal with even though they are more educated about it than they were after WWII. Brett shared copies of a Vet Center flyer. He said counselors will come to the county veteran's affairs office and conduct one-on-one counseling to prepare vets for group counseling. Services include:

- Individual readjustment counseling
- Group readjustment counseling

- Referral for benefits assistance
- Liaison with community agencies
- Marital and family counseling
- Substance abuse information and referral
- Community education
- Job counseling and referral
- Bereavement counseling

Brett said county office work to enroll the veterans and get them set up for services, then the services are delivered elsewhere.

Supportive Services:

- VA Homeless Grant and Per Diem Program – to promote the development and provisions of supportive housing and/or supportive services to help homeless vets achieve residential stability
- Housing and Urban Development-Veterans Assisted Supported Housing (HUD-VASH) – a cooperative partnership that provides long-term case management, supportive services, and permanent housing support. Eligible homeless vets receive case management and supportive services to support recovery and stability.

Outpatient Services include:

- Psychiatric services
- Assessments
- Patient education
- Nutritional assessments
- Depression screenings
- Substance abuse screenings
- Preventative health screenings

Mental Health Intensive Case Management (MHICM) – is a nationally developed program for those patients who would best benefit from intensive case management. The goals are to assist individuals to function at the highest possible level in the least restrictive environment. The program has been effective in decreasing re-hospitalizations.

Psychosocial Residential Rehabilitation Treatment Program (PRRT) – provides short and long-term supportive environments including assistance with community adjustment, interpersonal relations, and other issues. It includes classes and structure to help vets in transitioning from inpatient to outpatient status and maintaining stability in the community.

Therapeutic and Supported Employment Services (TSES) – this program was established for vets whose lives have been disrupted by mental illness or physical disabilities who would benefit from a structured approach to employment-related goals. The program uses work-based treatment to provide a continuum of vocational skill

development services including Incentive Therapy, Compensated Work Therapy, Supported Employment, and the Homeless Veterans Supported Employment Project.

Outreach and Supportive Services to Homeless Veterans – are part of the VA commitment to end homelessness among veterans. The comprehensive plan expands efforts for education, jobs, health care and housing.

- Veterans Justice Outreach workers link with jails, law enforcement, and court systems to help find alternatives to incarceration for homeless veterans involved with the criminal justice system.
- A Prisoner Re-Entry Specialist goes into state prisons and works with veterans who are being discharged to determine their needs and eligibility for services, and connect them with the VA or community agencies.
- Health Care for Homeless Veterans (HCHV) is an outreach program to identify veterans in homeless shelters and other locations and connect them with VA medical and mental health care.

Community Based Outpatient Center Programs (CBOCs) – Outpatient mental health services are provided through CBOCs in Knoxville, Mason City, Fort Dodge, Marshalltown, and Carroll. Services include medication management/administration, and group and individual therapies. Some services are provided through telehealth.

On average, one U.S. soldier commits suicide each day. There is an epidemic of mental injury among returning service men and women. Many of the mental health issues are related to Post Traumatic Stress Disorder.

- Trauma is any event outside the usual realm of human experience.
- Traumatic stress is a very intense arousal after the traumatic stressor that can happen any time from immediately after up to 1 or 2 years after a traumatic situation.
- PTSD is what happens after a critical event when the symptoms are not addressed and resolved.
- Sometimes symptoms only surface after several months have passed.
- Trauma membrane is a psychological defense system that insulates the person from trauma but also prohibits recovery.
- PTSD symptoms can be triggered by other stressful life events such as retirement, the loss of a spouse, or seeing continuing coverage of combat on television.

PTSD Statistics:

- 11 to 20% of veterans who served in Operation Iraqi Freedom and Operation Enduring Freedom
- 10% of veterans who served in Desert Storm
- 30% of veterans who served in Vietnam

PTSD Quick Facts:

- In FY 2011, over 476,000 veterans with a diagnosis of PTSD received treatment at VA medical centers and clinics
- In 2010 the process for veterans seeking health care and disability compensation for PTSD was simplified and made faster
- All veterans coming to the VA for the first time are screened for PTSD
- Treatment is recovery-oriented and focuses on individual needs and preferences
- There is a "PTSD Coach" mobile app available to help veterans manage their PTSD symptoms; it has been downloaded over 66,000 times in over 65 countries
- The VA has launched campaigns that aim to help veterans feel comfortable talking about PTSD and seeking help

Brett said the Vet Center will work with families as well as with the veteran.

More information is available at:
http://www.mentalhealth.va.gov/VAMentalHealthGroup.asp

PUBLIC COMMENT

No public comment was offered.

NEXT MEETING

The next meeting is scheduled for September 19, 2013 at the Pleasant Hill Public Library. The Regional Services System Committee will meet the evening before.

The meeting was adjourned at 2:40 p.m.

Minutes respectfully submitted by Connie B. Fanselow.